Written evidence from INQUEST Charitable Trust (STI0013)

1. INQUEST is the only charity providing expertise on state related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media, and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question, such as the Hillsborough disaster or Grenfell Tower fire. INQUEST sits on the cross governmental Ministerial Board on Deaths in Custody.

2. INQUEST has been involved in supporting bereaved families through various public inquiries, most notably the Grenfell Tower Fire inquiry.[1] Many of those we work with in the INQUEST Lawyers' Group – a national network of several hundred lawyers who provide legal advice and representation to bereaved families – have also worked on the Manchester Arena, Undercover Policing and Covid-19 inquiries.

3. Subsequently, INQUEST have witnessed what works well and what improvements can and should be made to the law and practice of public inquiries. In this submission, we outline four key recommendations we believe this committee should consider to improve the Inquiries Act 2005 (the Act), and in turn the public inquiry process, for bereaved families and victims of state failure:

    I. Establish a National Oversight Mechanism to collate, analyse and follow-up on recommendations made in public inquiry reports.
    II. Amend the Inquiry Rules to give the legal representatives of core participants the same right to ask witnesses relevant questions as exists in inquests.

[1] INQUEST has had some involvement in the Azelle Rodney, Anthony Grainger and Jermaine Baker inquiries into police shootings. INQUEST's Executive Director is currently involved in the public inquiry into the death of Sheku Bayoh in Scotland. INQUEST also provided an expert witness statement to the Brook House Inquiry and have submitted a response to the Lampard Inquiry's terms of reference. Older inquiries INQUEST was involved in include the Stephen Lawrence, Ashworth, Leveson and Mubarek inquiries.

III. Establish a statutory duty of candour on public authorities, public servants and corporations.
IV. Establish a central inquiries unit to help provide consistency to the setting up of inquiries and carry out evaluation on their completion.

Recommendation I: Establish a National Oversight Mechanism to collate, analyse and follow-up on recommendations made in public inquiry reports.

4. INQUEST is calling for the government to establish a new independent public body responsible for collating, analysing and following up on recommendations arising from inquests, inquiries, official reviews and investigations into state-related deaths (however for the purposes of this submission we will touch only on a Mechanism's relevance to public inquiries).[2]

5. Inquiries have been crucial in shining a light on areas of public importance such as state detention, policing, fire safety, child abuse, NHS failures and terror attacks. Inquiries can result in recommendations made with the aim of preventing future deaths and improving policy and practice. This is clearly in the public interest. In addition, inquiry recommendations have the potential to make the process more fulfilling for bereaved families and victims, who can see judicial recognition of failings or concerns. As Lord Bingham said regarding investigations into state-related deaths following the racist murder of Zahid Mubarek "*those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others*".[3]

6. Given the preventative function of public inquiries, it is deeply troubling that there exists no mechanism for following up on their recommendations. As this committee's 2014 report found, government response to recommendations was slow "*and its implementation of them slower still*".[4] Ten years on, this continues

[2] For more information, see INQUEST's briefing "No More Deaths. Learning, action and accountability: the case for a National Oversight Mechanism", https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=b480f898-7fbd-4c9c-a948-50dd3fad3a04, June 2023
[3] R(Amin) v Secretary of State for the Home Department ([2003] UKHL 51 [2004] 1 AC 653 §31
[4] Select Committee on the Inquiries Act 2005 – Report, The Inquiries Act 2005: post-legislative scrutiny, https://publications.parliament.uk/pa/ld201314/ldselect/ldinquiries/143/14302.htm, February 2014

to be the case: there is a lack of transparency on what changes, if any, have been made in response to inquiry recommendations; there is no official means of making organisations accountable for the lack of a response; and, there is no central oversight in place to monitor progress across inquiries. As a result, progress on inquiries is fragmented and can easily fall from the political agenda once media interest has dissipated, creating a culture of complacency.

7. This is in part contributed to by gaps in the Act. There is no legal mechanism to require consideration, action, or reasoned rejection of a recommendation made in the course of a statutory inquiry under the Act. Therefore, recommendations made by a statutory public inquiry have no legal force on the government, public authorities, corporations, or anyone else. Relatedly, the Act does not place a duty on relevant authorities to respond to recommendations within a certain timeframe.

8. A major impact of the current lack of oversight and follow-up is that bereaved families are left unaware as to whether progress has been made following an inquiry into the death of their loved one. This can have a considerable emotional toll on families and the impact of hearing about another similar death cannot be over-stated. It is often families and victims who push for an inquiry to be established and so the absence of a formalised process to monitor progress on its findings can undermine families' trust. As Grenfell Tower survivor and bereaved family member Hanan Wahabi said,

   "*72 people passed away and we can't bring our loved ones back. The impact it's had on our families and our community could have been prevented. We can't change that now, but we can change the lives of those we've lost to count, for their deaths not to have been in vain. There has to be change. We have to learn from this*."

9. There is broad recognition of the need for better follow-up to inquiries and concerns about the lack of follow-up have come from inquiry chairs themselves. For example Professor Alexis Jay, chair of the Independent Inquiry into Child Sexual Abuse, noted her frustration at the lack of "*in-built follow-up*" to check the progress made by government to her inquiries' recommendations.[5] Chair of

[5] For more information see https://www.shropshirestar.com/news/uk-news/2024/01/17/sex-abuse-inquiry-chair-frustrated-at-lack-of-quick-action-on-recommendations/

the Anthony Grainger Inquiry Judge Teague, now Chief Coroner, expressed concern regarding the lack of a proper system or national register for following up on statutory inquiry, inquest and Independent Office of Police Conduct recommendations made following fatal police shootings, stating,

"*[t]he danger that presently exists in the absence of the formality and discipline that such a register brings is that a patchwork quilt exists, in which knowledge of recommendations is variable and inconsistent.*"[6]

10. A lack of proper oversight to inquiry recommendations was also raised by many of this committee's witnesses.[7] As Mark Fisher noted, "*part of the legitimacy of a public inquiry has to be its recommendations. Their implementation is fundamentally important to that*."[8] This recognition has come from civil society as well: the Institute for Government found "*[t]he formal checks and procedures we have in place to ensure that public inquiries lead to change are inadequate*." Their research has shown that "*of the 68 public inquiries which have taken place between 1990 and 2017, only six of them have been followed up by a parliamentary select committee to examine the implementation of recommendations*."[9]

Grenfell Tower Fire

11. The absence of a system for adequately tracking the response to recommendations has, we believe, contributed to a lack of urgency in implementing key recommendations, as seen by the government's response to the Grenfell Tower Inquiry's

[6] Judge Teague went on to say "*Moreover, the existence of a register may assist in the prompt consideration of the recommendation: a recommendation is perhaps more likely to be put into effect – or at least dismissed on good and proper grounds – if the recommendation, and the response to it, are available for all relevant stakeholders to see. Finally, public confidence may also be enhanced if it can be seen that the recommendation has been responded to*." The Anthony Grainger Inquiry, Report into the Death of Anthony Grainger, https://assets.publishing.service.gov.uk/media/5d27151a40f0b611b680982e/Anthony_Grainger_Inquiry.pdf, July 2019

[7] While Brian Altman KC states there should be a statutory duty to respond to inquiry recommendations within a certain timeframe, both Kate Eves and Sir John Saunders were clear about the need for better follow-up, Statutory Inquiries Committee, Corrected oral evidence: statutory inquiries, Monday 12 February 2024, https://committees.parliament.uk/oralevidence/14346/pdf/, February 2024

[8] Statutory Inquiries Committee, Corrected oral evidence: Statutory inquiries, Monday 19 February 2024, https://committees.parliament.uk/oralevidence/14289/pdf/, February 2024.

[9] Institute for Government, How public inquiries can lead to change, https://www.instituteforgovernment.org.uk/summary-how-publicinquiries-can-lead-change, December 2017

recommendations in its report on Phase I of the Inquiry. According to the Home Office's latest report on the Inquiry's recommendations, four of the inquiries' eleven recommendations are still being considered.[10] Two of the four recommendations still to be implemented relate to Personal Emergency Evacuation Plans (PEEPs).

12. INQUEST share the concern of other civil society groups such as CLADDAG over the government's response to PEEPs recommendations. The Inquiry recommended the government make it a legal requirement on owners and managers of high-rise residential buildings to prepare PEEPs for all residents whose ability to self-evacuate in an emergency may be compromised. A disproportionate number of disabled residents died in the Grenfell Tower fire. Despite previous assurances from government Ministers that these recommendations would be implemented, the government eventually rejected the recommendation because of cost concerns. CLADDAG challenged this decision in the High Court, but the court ruled it was not unlawful.[11] While it is the right of government to reject inquiry recommendations, INQUEST believes the confusion and delays in moving forward with such crucial recommendations is wholly regrettable and does not inspire confidence over the government's response to the Inquiry's forthcoming Phase II report.

National Oversight Mechanism

13. In order to provide adequate transparency and oversight of inquiry recommendations, we believe a National Oversight Mechanism should be established. This would be a new, independent public body with the following three core functions:

    a. Collation: It should create and manage a new publicly available database which collates all recommendations made

[10] Home Office, Thematic update on progress against the Grenfell Tower Inquiry Phase I Recommendations, https://assets.publishing.service.gov.uk/media/65bd0c37c43191000d1a44d3/Progress_against_the_Grenfell_Tower_Inquiry_Phase_1_recommendations_Final_0224+version.pdf, February 2024

[11] CLADDAG challenged this decision in the courts arguing that the rejection of the recommendation included an unlawful consultation process, a failure to comply with the Public Sector Equality Duty, and was a breach of disabled residents' right to life and freedom from discrimination. This judicial review itself followed earlier judicial review hearings brought about by a bereaved family member. For more information see https://claddag.org/2023/07/14/high-court-finds-government-made-secret-political-decision-not-to-implement-grenfell-inquiry-recommendations-on-personal-emergency-evacuation-plans-peeps-for-disabled-people-but-r/, July 2023

following post-death processes such as public inquiries, highlighting the public agencies the recommendations are addressed to and the progress made on implementing them.

b. Analysis: Building on the information collated in its database, the Mechanism should issue regular reports to analyse the emerging themes and patterns in recommendations issued.
c. Follow-up: Due to its collation of information and analysis, a Mechanism will have oversight of the implementation of recommendations, or lack thereof. The Mechanism should then follow-up and alert the relevant bodies to escalate its concerns which could include government departments, select committees and, where appropriate, organisations with prosecution powers.

14. In terms of the powers a Mechanism might have, while decisions on actions following official recommendations is a democratic process for public or private bodies to take, they must be accountable for their response to life-saving recommendations. This means publicising information on action taken in response to recommendations, within a reasonable time, or issuing statements on the reasons for a rejection to a recommendation. INQUEST believes there should be sanctions on public bodies who do not disclose this information. In this way, we believe a National Oversight Mechanism would enable accountability by increasing transparency on the action, or inaction, of state and corporate bodies.

Power of inquiry chairs to monitor the implementation of their recommendations

15. In addition, consideration should be made to amending the 2005 Act to give chairs the express power to hold evidence sessions on the follow-up of recommendations within a certain time period following the publication of the inquiry's report.

16. INQUEST believe the practice of the chair in the Manchester Arena Inquiry should be emulated. Alongside general recommendations, the Inquiry chair made specific Monitored Recommendations[12] to be examined and reviewed during the course of the Inquiry, stating, "*I intend to scrutinise what has been done in*

[12] Manchester Arena Inquiry Volume 2: Emergency Response, Volume 2-II Report of the Public Inquiry into the Attack on Manchester Arena on 22nd May 2017, para 21.47, pg. 162

response to the Monitored Recommendations and use all of the powers available to me, if required, to achieve transparency and accountability." The chair then heard evidence on the progress of implementation of the Inquiry's recommendations and the organisations' approach to learning. This scrutiny of the Inquiry's recommendations not only provided meaning for victims and the wider public, but incentivised action from the recipients by scheduling official monitoring sessions.

17. While a positive example, we believe other inquiry chairs do not replicate this practice because the power is not expressly stated in the Act.[13] For example, when INQUEST asked the chair of the Grenfell Tower Inquiry to monitor recommendations and request regular updates from the recipients of recommendations, we received a response which stated the Act "*provides no formal power to the Chairman of an Inquiry to require that recommendations are implemented within any particular period of time or to be provided on a regular basis with information about how implementation is progressing*".[14] INQUEST believes much greater consistency is needed across inquiries with regard to following up their own recommendations. We believe amending the Act to make clear the power to hold sessions on the implementation of recommendations clear would give more inquiry chairs the power to follow the positive example of the Manchester Arena Inquiry.

18. The JUSTICE working group in their report 'When Things Go Wrong' suggested the incorporation of time limits for implementation when drafting recommendations. While this "*pragmatic approach*" was adopted by the Ladbroke Grove Rail Inquiry, the working group described it as "*atypical*".[15] Greater use of modules and interim reports during inquiries could also help provide scrutiny of progress on recommendations.

[13] However, other notable examples include IICSA and the non-statutory Birchard inquiry. For more information see here https://www.iicsa.org.uk/reports/process-monitoring-responses-inquiry-recommendations.html and here https://dera.ioe.ac.uk/id/eprint/6394/1/report.pdf

[14] Letter from Grenfell Tower Inquiry Secretary to INQUEST, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=a8812442-b412-4ad8-91b1-4caffe3b0820, 31 January 2020

[15] JUSTICE, When Things Go Wrong: The response of the justice system, https://files.justice.org.uk/wp-content/uploads/2020/08/06165913/When-Things-Go-Wrong.pdf, August 2020

19. INQUEST was particularly interested to note Sir John Saunders' comments on the way in which public inquiry chairs themselves can follow-up on recommendations. While in support of some form of scrutiny of recommendations from inquiry chairs, he went on to say that further follow-up may need to be facilitated by "*another layer of supervision…someone independent [that] can say to the public 'this is being done'*".[16] We believe a National Oversight Mechanism would appropriately fill this function, and that its independence from government could be secured by making it accountable to Parliament as opposed to a government department.

20. Further, while it has been suggested that parliamentary select committees are well placed to follow-up on inquiry recommendations, we believe there are risks to this approach. Firstly, select committees already have a high number of areas to investigate and it is questionable whether they would have the capacity to effectively follow-up on inquiry recommendations. Secondly, many inquiries span different government departments or issues and so its recommendations may not fit precisely into one committee's remit. Thirdly, while MPs and Peers hold extremely relevant expertise on many of the issues covered, they tend to quickly move on and off committees and so there is a risk of losing institutional knowledge. We believe a dedicated organisation such as a National Oversight Mechanism can better mitigate these risks and work in a complementary way with select committees, such as through sharing information.

Recommendation II: Amend the Inquiry Rules to give the legal representatives of core participants the same right to ask witnesses relevant questions as exists in inquests.

21. As this committee will be aware, lawyers for core participants are not entitled to directly question witnesses during public inquiry hearings. While Rule 10 of the Inquiry Rules states that questioning is permitted by core participants, they must make an application to the chair on the reasons for asking the questions, such as whether they raise new issues.[17]

[16] Statutory Inquiries Committee, Corrected oral evidence: statutory inquiries, Monday 12 February 2024, https://committees.parliament.uk/oralevidence/14346/pdf/, February 2024

[17] The Inquiry Rules 2006, https://www.legislation.gov.uk/uksi/2006/1838/made. It is noteworthy that Rule 10 only extends to the legal representatives of witnesses or core participants, and not to core participants themselves given the fact not all core participants will be entitled to legal aid or necessarily be legally represented.

22. This is a different practice to inquests, wherein lawyers can directly question witnesses without having to go through a coroner. Some public inquiries take on the role of an inquest, particularly in instances of a police shooting where evidence is considered subject to 'Public Interest Immunity' and requires judicial oversight. It is therefore inconsistent that families in inquests are able to ask witnesses questions directly via their lawyers whereas in inquiries this is not allowed.

23. Further, INQUEST believes the lack of a formal rule allowing for the express right of legal representatives of core participants to ask witnesses relevant questions is a major barrier to the effective participation of victims and bereaved families. It can result in families and others feeling as though an inquiry is something being done *to* them, rather than *with* or *for* them, and there is a concern the whole process becomes a technical one between counsel for the inquiry and the chair. As Lord Hendy of this committee stated during oral evidence sessions, it is "*difficult to see how a group of bereaved and injured who are not able to ask questions and are not represented […] would feel that they are sufficiently participating*."[18]

24. In addition, the practice and extent to which Rule 10 works effectively varies greatly across inquiries. As acknowledged in JUSTICE's report 'When Things Go Wrong', the way the rule is applied is discretionary to the particular inquiry chair. A strict interpretation of Rule 10 was applied during the Grenfell Tower Inquiry. In our Family Listening Day report with those bereaved by the Grenfell Tower fire, one of the key concerns raised was that lawyers did not have the power to ask questions. It was felt this removed families from the proceedings. The chair also imposed a five-day limit on lawyers being able to submit their suggestions for questions to witnesses. As a result, families told INQUEST this hindered their ability to digest the appropriate information. The below quotes come from INQUEST's report of the Grenfell Family Consultation Day:

"I can speak freely with legal representative but when my question gets passed to them [the Inquiry team] I don't feel like I'm being heard."

[18] Statutory Inquiries Committee, Corrected oral evidence: statutory inquiries, Monday 12 February 2024, https://committees.parliament.uk/oralevidence/14346/pdf/, February 2024

"If our lawyers had the chance to speak, it would have been far better. What are we doing there if we are not allowed to scrutinise."

25. We would also like to draw the committee's attention to the practice of the second Hillsborough inquests. While not a statutory inquiry, the inquests investigated the deaths of 97 individuals and took place over two years. Families felt able to participate in this process in part because of the power on behalf of their lawyers to ask questions.

26. To enable core participants to feel sufficiently included in the inquiry process, which very often centres on their experience, we believe the Act should be amended to state that core participants' legal representatives have the express right to ask relevant questions of witnesses. This will enable core participants, victims and the bereaved to feel included rather than ignored during proceedings and would address the inconsistency in how public inquiries and inquests are run. This should not be an unfettered right on the part of legal representatives and should be tailored to a specific set of circumstances with the chair retaining some level of control.[19]

27. This committee might also like to consider the good practice of other inquiries with regard to putting the voices of victims and the bereaved at the centre of the process. For example, pen portraits – which allow the inquiry to hear more about the person who has died – are a constructive way of doing this and have recently worked well at the Grenfell Tower and Sheku Bayoh inquiries. In addition, we believe the appointment of panels to inquiries which reflect the ethnic, cultural and religious diversity of a community can further allow for victims and the bereaved to feel represented.

Recommendation III: Establish a statutory duty of candour on public authorities, public servants and corporations.

28. Our work alongside bereaved families and victims in public inquiries has very often revealed the problem of a lack of candour

[19] See, for example, JUSTICE's recommendation in its report 'When Things Go Wrong: The response of the justice system': "Rule 10(4) of the Inquiry Rules 2006 should be amended to allow the legal representative of a core participant to ask questions of a witness where Articles 2, 3 or 4 ECHR are engaged. The chair should retain discretion to refuse (with reasons) a line of questioning and to impose time limits on any questioning", https://files.justice.org.uk/wp-content/uploads/2020/08/06165913/When-Things-Go-Wrong.pdf, August 2020

on the part of relevant organisations involved. As a result, INQUEST has long called for the establishment of Hillsborough Law, or the Public Authority (Accountability) Bill.[20] A key part of the Bill is the duty of candour: a codified requirement on public servants, public authorities and corporations to act in the public interest and proactively and truthfully assist investigations, inquests and inquiries of all official kinds, at the earliest possible point, including by the disclosure of all relevant documentation and position statements in which they must set out their narrative of what happened and what went wrong.

29. While the duty of candour as proposed in Hillsborough Law would apply to all investigatory processes, and so would not be something which could be incorporated into the Act, we believe this committee should consider its potential benefits to the conduct of public inquiries.

30. For instance, INQUEST believes a duty of candour would have a positive impact on the efficiency and effectiveness of public inquiries. Lack of candour frustrates the fundamental purpose of inquests and inquiries: to reach the truth and learn from mistakes so that similar tragedies do not occur in the future. Previous examples have shown how public bodies, such as the police, have consistently approached inquests and inquiries as if they were litigation, failing to make admissions and often failing to fully disclose the extent of their knowledge surrounding fatal events.[21] By compelling co-operation, a statutory duty of candour would enable inquests and inquiries to fulfil their function of reaching the

[20] Public Authority (Accountability) Bill, https://bills.parliament.uk/bills/1978, April 2017

[21] For example, the South Yorkshire Police have been repeatedly criticised for their institutional defensiveness in respect of the 1989 Hillsborough disaster. A 1989 briefing within the Prime Minister's office on the Interim Taylor Report into the Hillsborough disaster noted that "*senior officers involved sought to duck all responsibility when giving evidence to the Inquiry*", that the "*defensive – and at times close to deceitful – behaviour by the senior officers in South Yorkshire sounds depressingly familiar*" and that "*[t]oo many senior policemen seem to lack the capacity or character to perceive and admit faults in their organisation*". In her 2017 review of deaths and serious incidents in custody, Dame Elish Angiolini concluded: "*it is clear that the default position whenever there is a death or serious incident involving the police, tends to be one of defensiveness on the part of state bodies*". Additionally, the chair of the statutory Anthony Grainger inquiry, HHJ Teague QC, concluded that "*it [was his] firm view that an unduly reticent, at times secretive attitude prevailed within [Greater Manchester Police]'s [Tactical Firearms Unit] throughout the period covered by this Inquiry*." For more information, see JUSTICE and INQUEST's briefing to the Police, Crime, Sentencing and Courts Bill, Amendment 71 – Accountability of public authorities: duties on police workforce, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=2652a013-001b-49ab-a1d5-6af7b8076589, February 2022

truth in order to make pertinent recommendations which address what went wrong and identify learning for the future.

31. Further, failure to make full disclosure and act with transparency can lead to lengthy delays as the investigation or inquiry grapples with identifying and resolving the issues in dispute, at cost to public funds and public safety. A recent example is the Daniel Morgan Independent Panel, which was refused proper access to the Home Office Large Major Enquiry System (HOLMES) by the Metropolitan Police Service (MPS) over seven years. The Panel needed access to HOLMES to review the MPS' investigations into Daniel Morgan's murder, but the lengthy negotiations with the MPS about the Panel's access led to "*major delays to the Panel's work*". These delays added to the Panel's costs and furthered unnecessary distress to the family of Daniel Morgan. The Panel concluded that the MPS were "*determined not to permit access to the HOLMES system*".[22] A statutory duty of candour would direct the investigation to the most important matters at an early stage. This would strengthen the ability of the inquiry or investigation to reach the truth, and to do so without undue delay.

32. A practical way in which the duty of candour can be complied with is through ordering position statements from the parties involved in an inquiry. Indeed, Hillsborough Law states that in discharging the broader duty of candour, public bodies should "*set out their position on the relevant matters at the outset of the proceedings, inquiry or investigation*".[23] Position statements are used in other court jurisdictions, including criminal and family courts (although they are not always referred to as such). In position statements, those involved must state what they believe the key issues are from the outset of proceedings.

33. An example in which ordering position statements worked well is the review held into a near-fatal accident which occurred during the UEFA Champions League final in Paris in 2022. The panel in this inquiry sent requests for position statements to each of the involved

[22] The Report of the Daniel Morgan Independent Panel, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/993985/_HC_11-III__-_The_Report_of_the_Daniel_Morgan_Independent_Panel__Volume_3_.pdf, June 2021

[23] Public Authority (Accountability) Bill, https://bills.parliament.uk/bills/1978, section 1, (3)(e), April 2017

stakeholders, as they were called in this inquiry. The requests asked stakeholders specific questions which they wanted to hear about. Positively, almost all stakeholders responded. It led to the collection of evidence, helped the panel identify and obtain other necessary evidence and determine who they should interview and what questions to ask.[24]

Recommendation IV: Establish a central inquiries unit to help provide consistency to the setting up of inquiries and carry out evaluation on their completion.

34. In this committee's 2014 report on the Act, it recommended the government create a unit responsible for the setting up of both statutory and non-statutory inquiries to assist the chair with infrastructure, IT, procurement and staffing concerns. In addition, it recommended the unit ensure 'Lessons Learned' papers were produced at the end of inquiries "*from which best practice can be distilled and continuously updated*."[25]

35. INQUEST fully supports this recommendation. There are currently over ten open public inquiries, which are being conducted in separate ways without an established forum for learning or evaluation.[26] We believe the absence of any unit to evaluate the conduct of an inquiry has resulted in a lack of institutional knowledge on inquiries, the repetition of failings and an unnecessarily inconsistent approach.

36. The lack of consistency in how public inquiries are set up can have distressing consequences for bereaved families. For example, the first choice of venue for the Grenfell Tower Inquiry was completely inadequate for the needs of families and survivors and was later changed to a larger building in West London. It is crucial the learning from this is formally shared with other inquiries to avoid the same thing happening again.

[24]UCLF22, Independent Review, 2022 UEFA Champions League Final, https://editorial.uefa.com/resources/027e-174e23083d46-84d25c2e6e55-1000/uclf22_independent_review_report_20230213194627.pdf, February 2023

[25] Select Committee on the Inquiries Act 2005 – Report, The Inquiries Act 2005: post-legislative scrutiny, https://publications.parliament.uk/pa/ld201314/ldselect/ldinquiries/143/14302.htm, February 2014

[26] Parliamentary Question from Lord Norton of Louth to the Cabinet Office on Inquiries, https://questions-statements.parliament.uk/written-questions/detail/2024-02-13/HL2446#answer, February 2024

37. Given the risk of inquiry hearings retraumatising bereaved families and victims, an inquiries unit could also help coordinate trauma-informed support agencies to work with victims and core participants during inquiries, a practice which has been variable across inquiries.

38. We believe it is crucial that any unit maintains independence from government as well as from the operation of inquiries once they have been set up. The unit should be able to independently evaluate inquiries, which an advisory board made up of bereaved families would be able to assist them in, however it is paramount that a government agency does not have any influence on the way in which an inquiry is run.

Conclusion

39. Statutory inquiries are a vital way of ensuring public accountability following state-related deaths or human rights violations. The reports from inquiries are a source of useful information for policy makers, researchers and the general public. Further, when families and victims are truly put at their centre, inquiries can provide some catharsis for them.

40. An inquiries' potential to facilitate meaningful, positive change is great, but so too are the numerous issues which undermine the process. As this submission makes clear, more robust oversight to recommendations, firmer processes to enable bereaved families and victims' participation, a move toward candour, and a central unit to facilitate learning are long overdue reforms needed to improve the law and practice of public inquiries.

22nd March 2024